Medicare Payment Advisory Commission

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June 2, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

RE: File Code CMS-1783-P

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; FY 2024 Inpatient Psychiatric Facilities (IPFs) Prospective Payment System (PPS)—Rate Update; Proposed Rule," *Federal Register* 88, no. 68, 21238–21314 (April 4, 2023). We appreciate your staff's continuous efforts to administer and improve the Medicare payment system for IPFs, particularly given the competing demands on the agency.

Our comments relate to the proposed wage index calculation, data collection and improved methods to refine IPF PPS payments, and developing patient experience measures.

Wage index adjustment

Since the start of the IPF PPS, CMS has used general acute care hospital wage data to develop the IPF PPS wage index. For fiscal year (FY) 2024, CMS proposes to continue to use the unadjusted inpatient prospective payment systems (IPPS) wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index").

Comment

The Commission has long been concerned with flaws in the wage indexes Medicare uses to adjust provider payments to reflect geographic differences in labor costs.[1] To improve the

[1] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

accuracy and equity of Medicare's wage index systems for inpatient prospective payment system hospitals and other providers (such as, but not limited to, IPFs), Medicare needs wage indexes that are less manipulable, more accurately and precisely reflect geographic differences in market-wide labor costs, and limit how much wage index values can differ among providers that are competing for the same pool of labor. In the Commission's forthcoming June 2023 report to Congress, we recommended that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new Medicare wage index systems for hospitals and other types of providers that:

- use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
- reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- smooth wage index differences across adjacent local areas.

It appears the Secretary has authority to determine what wage index measure is most appropriate to apply to IPF payments, and we urge the Secretary to adopt the Commission's recommended approach for IPFs.

Request for information on additional data collection

The Consolidated Appropriations Act (CAA), 2023, requires CMS to collect additional information on IPFs' resource use, patient monitoring, and interventions in order improve the accuracy of IPF PPS payments. This data collection is required to begin by October 2023, and the data collected must be incorporated into the IPF PPS for FY 2025. CMS is requesting comments on additional data that would improve the IPF PPS, mechanisms to collect that information, and on possible revisions to the payment methodology. The CAA, 2023, also requires that CMS develop a patient assessment tool to capture additional characteristics of IPF patients (such as functional and cognitive status), to be implemented by 2028. CMS is not yet requesting comment on this patient assessment tool.

Comment

For our forthcoming June 2023 report to the Congress, we examined the provision of IPF services to Medicare FFS beneficiaries. We analyzed use, spending, and indicators of payment adequacy, such as access to care, quality of care, and Medicare payments and provider costs. We also conducted interviews with 10 IPFs on topics such as the types of services provided to Medicare beneficiaries (and whether these differ by type of IPF), how these services differed by patient characteristics, the provision and reporting of ancillary services, and general perceptions related to Medicare payment.

Our analyses of the IPF PPS showed that the current adjusters in the payment system are not sufficient for differentiating the costs associated with patients with different diagnoses.

Misalignment of payments and costs creates incentives for providers to admit certain types of patients and avoid others. The Commission contends that more information is needed to understand the drivers of IPFs' costs in caring for Medicare beneficiaries and to ensure that payments are aligned with those costs. Below, we discuss three suggestions to improve the accuracy of IPF PPS payments.

Collect information on staffing

Labor is the primary component of IPFs' costs: CMS calculated the labor share of costs to be 78.5 percent for FY 2024 (77.4 percent for FY 2023). This is higher than most other institutional settings (e.g., labor costs comprise less than 70 percent of IPPS hospital costs, 73 percent of inpatient rehabilitation facility costs, and 71 percent of skilled nursing facility (SNF) costs). However, there is little available information on the mix (and amount) of staff employed by IPFs and how staff spend their time across various IPF tasks (such as inpatient assessment, counseling, drug management, nursing care, and behavioral monitoring). IPF staffing data would provide essential insights into the variation in costs and quality of care across providers, enabling CMS and Medicare beneficiaries to better understand the services they are purchasing and using. There is a precedent for regularly collecting staffing information: SNFs are required to submit detailed staffing data through the Payroll Based Journal. Payroll data are considered the gold standard for measuring staffing; the data are submitted electronically and can be audited by other data sources.[2] Researchers have found the SNF payroll data to be consistent and accurate; the data serve as an important tool for policymakers to monitor staffing and assess its relationship to patient outcomes.[3]

Require the reporting of ancillary services

In the RFI, CMS requested comment on whether it would be appropriate for Medicare to reject IPF claims without ancillary charges reported. The Commission agrees that CMS should reject IPF claims that do not contain ancillary services. For years, CMS has been concerned about the reporting of certain ancillary costs and charges by IPFs, particularly noting stays with no or very low drug and laboratory costs. The expectation is that most patients requiring hospitalization for behavioral health treatment would need drugs and laboratory services and that the IPF base rate should include the costs of all ancillary services. The lack of data on drug costs, laboratory services, and other ancillary costs undermines CMS's ability to measure patient costs accurately. A study commissioned by MedPAC found that the calculated payment weights could not adequately capture the range of patient case mix (i.e., there was compression in the IPF payment

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[2] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023. Medicare program; prospective payment system and consolidated billing for skilled nursing facilities; updates to the quality reporting program and value-based purchasing program for federal fiscal year 2024. Proposed rule. *Federal Register* 88, no. 68 (April 2023): 21316–21422.

[3] Zheng, Q., C. S. Williams, E. T. Shulman, and A. J. White. 2022. Association between staff turnover and nursing home quality—Evidence from payroll-based journal data. *Journal of the American Geriatrics Society* 70, vol. 9: 2508–251.

Geng, F., D. Stevenson, and D. Grabowski. 2019. Daily nursing home staffing levels highly variable, often below CMS expectations. *Health Affairs* 38, vol. 7: 1095–1100.

weights due to the lack of variation in patient costs).[4] Although CMS has issued multiple transmittals to improve the reporting of ancillary costs on the cost reports, many IPFs continue to not report ancillary services. Rejecting claims without ancillary services would better enforce this requirement. Further, through our IPF interviews, we learned that some state Medicaid programs currently reject claims that do not appropriately report ancillary services. To ensure that facilities are paid for the small number of cases in which no ancillary services were provided, the agency could consider adding a modifier option to the claim.

CMS should also clarify the requirements related to IPFs' "all-inclusive-rate" hospital status. IPFs that do not have a charge structure (historically, government-owned psychiatric hospitals, according to CMS) can be exempt from the requirement to report ancillary services on cost reports as all-inclusive-rate hospitals. We have observed in cost report data that IPFs that previously were not all-inclusive-rate hospitals have recently changed to an all-inclusive-rate status. The timing of many of these changes appears to correspond to CMS's transmittals requiring ancillary services to be reported on cost reports for IPFs that do not have an all-inclusive rate. The approval process for the all-inclusive-rate status should be clarified and requirements enforced.

Update the payment methodology using more current data

The Commission supports using more recent data to update the IPF PPS adjustments to improve the accuracy of IPF payments. A study commissioned by CMS last year found substantial changes to diagnosis-related groups (DRGs) and comorbidity adjustments when using more recent data to calculate IPF PPS adjustments.[5] For example, using 2018 data, the regression coefficient on DRG 887 (other mental disorder diagnosis) increased by 33.7 percent compared to the current coefficient. That is, cases assigned to this DRG would receive a higher payment if more recent data were used to calculate IPF PPS adjustments. In addition, the rural adjustment under the IPF PPS has been set at 17 percent since the start of the payment system. Using updated data, the CMS study found that rural location was associated with an 11 percent increase in IPF costs. The Commission supports a rural adjustment that improves payment accuracy for all IPFs and promotes spending Medicare dollars efficiently. A study commissioned by MedPAC also found that the original payment weights differed substantially from those estimated with more recent data and advised that updates to payment adjustments be implemented as soon as feasible.[6] We urge CMS to implement the updated adjustments even while the agency concurrently considers other refinements to the payment system.

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[4] Medicare Payment Advisory Commission. 2022. *Medicare's prospective payment system for inpatient psychiatric facilities at 15 years.* Report prepared for MedPAC by the Urban Institute. https://www.medpac.gov/wp-content/uploads/2022/05/Apr22_IPF_CONTRACTOR_SEC.pdf.

[5] Centers for Medicare & Medicaid Services, Department of Health and Human Services. Inpatient psychiatric facility PPS. https://www.cms.gov/medicare/medicare-fee-for-service-payment/inpatientpsychfacilpps.

[6] Medicare Payment Advisory Commission 2022, *op cit.*

Adopt the Psychiatric Inpatient Experience (PIX) survey in the IPF quality reporting program

CMS proposes to adopt the Psychiatric Inpatient Experience (PIX) survey to measure patient experience of care in the IPF setting as a part of the IPF quality reporting program (QRP). The PIX survey was developed by a team at Yale University and Yale New Haven Psychiatric Hospital to address the gap in available experience of care surveys, specifically the lack of publicly available, minimally burdensome, psychometrically validated surveys specified for the IPF setting. The survey contains 23 items across four domains: 1) relationship with treatment team, 2) nursing team, 3) treatment effectiveness, and 4) healing environment.

CMS proposes that voluntary reporting begin in 2026 (based on surveys collected in calendar year 2025), with required reporting in 2027 (based on surveys collected in calendar year 2026) for the FY 2028 payment determination. IPFs would be responsible for administering the survey and for then reporting these data to CMS.

Comment

The Commission supports CMS's proposal to include a patient experience survey in the IPF QRP. We maintain that Medicare quality programs should include measures tied to clinical outcomes, patient experience, and value/resource use. Broader outcomes and patient experience measures that matter to patients and translate to better health are needed and are especially crucial given the vulnerability and high risk of IPF patients.

The Commission encourages CMS to move from requiring that IPFs collect the surveys in the facility to requiring that IPFs work with an approved third-party survey vendor to collect survey results from patients after discharge. The requirement to use a third-party to collect patient experience results is commonplace throughout Medicare quality programs.[7] Survey vendors are organizations that are independent from the providers they are evaluating, which allows them to gather information from patients without bias or influence from the provider. As a part of the approval process, survey vendors must demonstrate that they ensure confidentiality and privacy, which is especially important given the sensitivity of patient-level responses. We acknowledge that requiring a survey vendor to collect IPF patient experience responses post-discharge has associated administrative costs for IPFs and that there are challenges in collecting post-discharge surveys from populations served by IPFs (e.g., beneficiaries who are homeless or at risk of becoming homeless). But, as CMS eventually moves to publicly reporting the IPF patient experience results on Care Compare, it is important that patients and consumers have accurate and reliable results to inform their decision-making.

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[7] CMS requires Medicare Advantage plans, accountable care organizations, hospitals, home health agencies, hospices, and clinician groups to contract with approved survey vendors to collect Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

Conclusion

We appreciate the opportunity to comment on these important policy proposals. The Commission values the ongoing collaboration between CMS and MedPAC staff on technical policy issues, and we look forward to continuing this relationship.

If you have any questions, or require clarification of our comments, please do not hesitate to contact James E. Mathews, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

MC/BF